



**Report on the
Investigation into
Deaths at
Oaklands Regional Centre**



Introduction

On January 11, 2005, the Chief Coroner publicly announced that a review would be conducted into 10 deaths involving residents of Oaklands Regional Centre in Oakville between January 2000 and November 2004. The review was initiated in response to the tragic death of a resident who went missing from the facility and was subsequently found deceased. In response to the investigation of that death, a number of other issues arose and it was determined that a review of the circumstances of other deaths was appropriate.

The investigation was conducted from January to May 2005 by a team consisting of coroners and police officers. The team was subsequently expanded to include a general surgeon, psychiatrist and family practitioner.

The charts of 10 deaths that occurred from January 2000 – November 2004 were reviewed by the team. Some of these residents had lived at Oaklands for over 20 years. In addition to being developmentally challenged, each of the deceased individuals had complex medical histories.

Interviews were conducted with staff and management from Oaklands, families of the deceased, medical providers and representatives from the Board of Directors and Families Association at Oaklands as well as staff from the Ministry of Community and Social Services.

The objective of the review was to determine if there were any common elements in the circumstances surrounding the deaths, whether any significant issues could be identified and whether it was necessary and appropriate to conduct a coroner's inquest into any or all of the deaths reviewed.

This report outlines the findings from this review.



Overview – Oaklands Regional Centre

Oaklands provides both residential and non-residential programs for adults and children with developmental disabilities. Many of the residents have other disabilities such as mobility, medical, psychiatric and behavioural issues. Oaklands has been identified as having the expertise to successfully support individuals with more complex levels of need and has been providing services to this community since 1975.

Oakland's residential program provides room, board, support, supervision and personal care as required. Social, recreational and day programming are also available. Many residents receive specialized programming from psychologists, speech pathologists, occupational therapists and psychiatrists. These specialized clinicians are retained on a fee-for-service basis and scheduling ranges from a few hours per month, to 8-10 hours per week, depending on funding. Oaklands also offers a respite house facility to accommodate families for short-term stays.

Oaklands falls primarily under the jurisdiction of the Ministry of Community and Social Services and is incorporated as a not-for-profit corporation. Oaklands is a registered charitable organization and is governed by a volunteer Board of Directors elected by the corporation membership.

Oaklands is funded by the Ministry of Community and Social Services and also through the Ontario Disability Support Plan (ODSP) and charitable donations. In the mid-1990's, Oakland's financial resources were significantly reduced as a result of change in client base and provincial budget constraints.

As of December 2004, Oaklands Regional Centre had a total of 156 employees and provided residential services for 67 clients. Of the 156 employees, 97 were frontline, direct care staff in the residential program (59 full time, 13 regular part time and 25 relief/casual workers). The staff members that were interviewed are an experienced group of individuals with between three and 27 years of service. Of the staff interviewed during this review, it was identified that there was a cumulative total of more than 350 years of experience in caring for Oakland's residents.



The Investigative Team

The Investigation Team was composed of:

Dr. Bonita Porter	Deputy Chief Coroner - Inquests, Office of the Chief Coroner
Dr. Dirk Huyer	Coroner Central Region
Det. S/Sgt. Tom Girling	Ontario Provincial Police
Cst. Phil Campbell	Halton Regional Police Service
Det. David McCartney	Halton Regional Police Service

During the investigation, it was evident that additional expertise was necessary to review the complex medical histories of the cases involved. The team was subsequently expanded to include a general surgeon, psychiatrist and family practitioner with expertise in providing medical care to patients with developmental disabilities.



Method of Investigation

The investigation was conducted from January to May 2005. The team reviewed the charts of 10 deaths that occurred from January 2000 – November 2004. Interviews were conducted with staff and management from Oaklands, families of the deceased, medical providers and representatives from the Board of Directors and Families Association at Oaklands as well as staff from the Ministry of Community and Social Services.

The Investigative Team was divided into two sub-teams, each consisting of a coroner and police detective. Each sub-team was assigned five cases to investigate. Upon reviewing each of the five cases assigned, the team collectively reviewed all cases in order to ascertain if there were any commonalities or areas requiring further review.

As a result of the collective overview of the cases, and owing to the complex medical histories of the cases involved, additional input was sought from relevant individuals with clinical experience in addressing the needs of developmentally challenged adults. These individuals were asked to review specific cases requiring further, specialized examination.



Investigation Results

The residents who were the subject of the review ranged in age from 22 to 57 years and resided at Oaklands for between one and 27 years. All had a combination of complex medical, psychiatric and/or developmental disabilities.

For each of the cases, the answers to the five questions – the identity, the how, when, where and by what means the death occurred are known.

Three residents died as a result of tragic accidents. One resident with severe spastic quadriplegia died as a result of becoming trapped between the mattress and bedrails. In response to this death, all the beds at Oaklands were changed to prevent this occurrence from happening again.

Another resident who had a history of epilepsy but had been seizure-free for a number of years drowned in a bathtub after having been left alone for a short time. This is a hazard for individuals with epilepsy and in response to this death the policies for supervision of residents and bathing practices were reviewed, revised and re-enforced. The third resident drowned after wandering from the facility. In response to this death a review of the facility by the Ministry of Community and Social Services was conducted and a number of changes to the facility and its security have been implemented.

In these three cases, this review has not identified other matters in the circumstances leading to the deaths that merit additional public attention or recommendation.

Of the remaining deaths, three died from natural disease and a review of the circumstances raised no issue for specific recommendations. One resident died in hospital from natural disease but the death was not reported to a coroner. This event is the basis of a recommendation.

The remaining three residents who died during the period of this review died from complications of gastrointestinal blockages or perforations. One resident had an acute event that could not have been predicted. The staff identified the serious condition and responded appropriately in seeking medical attention. The other two residents died from complications of a disease known as pica (a disease of chronic ingestion of non-nutrient substances). A review of these three cases has identified areas that are the basis for some of the recommendations.



Decision Regarding Inquest

In determining whether or not an inquest should be held into one or more deaths of residents at Oaklands, reference must be made to Section 20 of the Coroners Act.

Section 20 states:

When making a determination whether an inquest is necessary or unnecessary, the coroner shall have regard to whether the holding of an inquest would serve the public interest, and, without restricting the generality of the foregoing, shall consider,

- a) whether the matters described in clauses 31(1) (a) to (e) are known;
- b) the desirability of the public being fully informed of the circumstances of the death through an inquest
- c) the likelihood that the jury on an inquest might make useful recommendations directed toward the avoidance of death in similar circumstances.

Having reviewed the circumstances of the 10 deaths, the conclusion is that it is not in the public interest to call an inquest into any one death, nor is it recommended that one inquest be called into more than one death.

While it is not felt that an inquest is necessary, the Investigative Team identified issues that form the basis for the recommendations presented in this report. The recommendations made are not meant to point blame or assign responsibility at any individual or organization, but rather are intended to prevent future similar deaths.



Recommendations

To Oaklands Regional Centre:

1. **It is recommended that a comprehensive approach for the management of pica be developed. This approach should include:**
 - identification of the presence of pica
 - notification mechanism to ensure staff are aware of the diagnosis
 - an approach to ensure safety of the environment for patients with pica
 - identification of complications of pica, i.e: incomplete bowel obstruction secondary to ingestion of foreign material
 - a clinical approach to evaluation of a patient with pica who has abdominal complaints

Rationale: Pica involves repeated or chronic ingestion of non-nutrient substances of different types and is more common in persons with developmental disabilities. The diagnosis of the complications of pica is often difficult and may be even more difficult in this population because of high pain tolerance and limited communication ability.

2. **It is recommended that there be a review of the complement and qualification of staff that provide health care at the Oaklands Regional Centre. This review should include careful consideration of an on-site, full-time health care resource such as a nurse practitioner who has specific expertise in the medical and psychiatric care of the developmentally disabled.**

Rationale: Our review demonstrated that there has been a reduction in the complement of registered nurses at Oaklands Regional Centre. This reduction has led to an increased reliance on non-health care staff to identify and interpret the symptoms of potential health problems. Regular contact with residents by an on-site health practitioner would enhance the ability for early recognition of these problems.



3. **It is recommended that Oaklands Regional Centre facilitate the attendance of health care providers at relevant continuing medical education programs.**

Rationale: Medical and psychiatric care of the developmentally disabled is a specialized area of medicine. Attendance at continuing education programs would facilitate awareness of new treatment approaches and provide opportunities for networking with others involved in the care of this unique population.

4. **It is recommended that Oaklands Regional Centre collaborate with Halton Health Services - Oakville Site to develop an education program for the hospital staff about the unique health care needs of the residents of Oaklands.**

Rationale: Residents of Oaklands who require emergency medical care are taken to the Halton Health Services - Oakville Site. Health care of the developmentally disabled is complex and challenging. Approaches to care, including examination techniques utilized by the health care professionals at Oaklands, could be shared with the hospital staff to assist with provision of health care.

5. **It is recommended that there should be a review of the processes in place for the administration of medication.**

Rationale: The investigation did not demonstrate any direct correlation between an error in the administration of medication and the death of a resident. However, irregularities in the dispensing of medication were noted.



6. **It is recommended that Oaklands Regional Centre develop a patient profile for each of its residents. This profile should include information such as medical history, medications, allergies and sensitivities, next-of-kin or substitute decision makers and ongoing behavioural and health issues.**

Rationale: It was evident in reviewing these cases that complete and accurate information was essential to the provision of appropriate care. Inconsistent charting proved problematic in assessing the resident. An up-to-date, legible patient profile that provides a comprehensive medical background, should accompany the resident when presenting to on-site and off-site health care professionals.

To the Ministry of Community and Social Services and Oaklands Regional Centre:

7. **It is recommended that the Ministry of Community and Social Services and the Board of Directors of Oaklands Regional Centre clarify the nature of services to be provided at Oaklands Regional Centre.**

Rationale: It became apparent during the investigation that the confusion resulting from inconsistent messages regarding the future of Oaklands had an impact on the staff and the provision of services to its residents.

8. **It is recommended that once a decision regarding the future role of Oaklands is reached, an operational review be conducted to ensure that adequate resources are made available to fulfill that role.**

Rationale: The investigation revealed that a reduction in management and nursing support, reduction in resident programs and funding for infrastructure, such as security, might have impacted the quality of services to Oaklands residents.



To the Ministry of Community and Social Services:

9. **It is recommended that the Ministry of Community and Social Services collaborate with the Ministry of Health and Long-Term Care to develop incentives for health care professionals to provide care for the developmentally disabled.**

Rationale: The review has demonstrated that medical care of the developmentally disabled is complex and time consuming. There are very few health care practitioners who are available to provide care to this unique patient group.

10. **It is recommended that the Ministry of Community and Social Services ensure timely reporting of all deaths in order to comply with the Coroners Act S. 10 (2)(d).**

Rationale: The Coroners Act requires that deaths of residents in facilities defined in the Developmental Services Act are reported and investigated. This investigation revealed that there was some misunderstanding about the duty to report the death when a resident dies in another location.

To the Office of the Chief Coroner:

11. **It is recommended that the Office of the Chief Coroner examine the current processes for reviewing coroners' investigation reports in order that recommendations made by investigating coroners are given due consideration.**

Rationale: In the course of this investigation, it was noted that in 2000, an investigating coroner had requested additional assistance in the form of a Regional Coroner's Review of a select number of deaths at Oaklands. This review process would involve additional investigation and typically results in a number of recommendations that are presented to an institution.

We were unable to determine if this request was noted or considered. This may have been a missed opportunity to identify issues for Oaklands and the Ministry of Community and Social Services.



Conclusion

It was most evident during the course of the investigation that there are a group of dedicated professionals who provide care to the residents of Oaklands Regional Centre. The Investigative Team experienced only eager cooperation and a willingness to identify what, if anything could have been done differently for the residents of Oaklands.

The Investigative Team would like to acknowledge the support and understanding of the families that were contacted in the course of this review.

It is hoped that the issues identified in this report will provide an opportunity for the improvement of care for individuals with complex developmental disabilities.

This report will be forwarded to the Chief Coroner for the Province of Ontario for consideration.